SAN ANTONIO INDEPENDENT SCHOOL DISTRICT

WORK STATUS FORM

Employee's Name	Physician	Primary (Dx) ICD-9	☐ Initial Visit ☐ Follow Up
Date of Injury/Illness	Physician Telephone No.		Employer's Name: **San Antonio ISD**
Social Security No.	Physician Address		Employer's Fax# or E-mail address: **299-5529**
Date of This Visit	Type of Injury/Illness		

Dear Medical Provider:
It is our understanding that you are currently treating the above-named employee. San Antonio ISD has a Modified Duty Program in which employees with physical restrictions are allowed to return to work to perform job duties within their physical capabilities. Please complete the information below and return this form to our office. If you have any questions regarding our Modified Duty Program, please contact Employee Benefits and Risk Management at 299-5576 or 299-5642.

WORK STATUS INFORMATION (*Select one option*)

Check the employee's medical condition:

☐ has been resolved and the employee may **return to work without restrictions** as of _____ (date).

☐ has improved enough to allow the employee **to return to work with restrictions** as of _____(date). The restrictions on the employee's work activities are noted below on this report and are expected to last until at least _____ (date).

☐ is such that the employee is **unable to work** and restricted from all work as of _____ (date). This restriction is expected to last until _____(date) at which time the employee is expected to be able to return to work with or without restrictions.

WORK RESTRICTIONS

GENERAL WORK RESTRICTIONS

☐May only work _____ hours / day
☐Sedentary only
☐Must wear splint / cast at work
☐Must use crutches at all times
☐Dressing changes necessary at work
☐No driving / operating heavy equipment
☐Can only drive automatic transmission
☐No skin contact with: _____
☐No work in extreme hot/cold environments
☐No work at heights or no scaffolding
☐No Work in water
☐Must Keep: ☐Elevated ☐Clean & dry
☐Stretching breaks every _____ hours

POSTURE / MOTION RESTRICTIONS

Employee has **no** posture restrictions
Employee has posture restrictions as follows:

Hours per day *(Check column)*	**1-4**	**4-6**	**6-8**
Standing			
Sitting			
Kneeling/Squatting			
Bending/Stooping			
Twisting			
Pushing/Pulling			
Overhead reaching			

LIFTING RESTRICTIONS
The employee is able to:
Lift objects without restriction
Occasionally lift a maximum of ____ lbs.
Frequently lift a maximum of _____ lbs
and
Carry objects weighing up to _____ lbs.

Employee has **no** motion restrictions
Employee has motion restrictions as follows:

Hours per day *(Check column)*	**1-4**	**4-6**	**6-8**
Grasping/Squeezing			
Keyboarding			
Wrist flexion/extension			
Overhead reaching			
Climbing stairs/ladders			
Walking			

RESTRICTIONS SPECIFIC TO
(if applicable)
☐L Hand/Wrist ☐R Hand/Wrist ☐Neck
☐ L Arm ☐R Arm ☐ Back
☐ L Leg ☐R Leg
☐L Foot/Ankle ☐R Foot/Ankle
☐Other:

FOLLOW-UP APPOINTMENT INFORMATION

Expected Follow-up Service Include: _____(Date) _____(Time)

Physician Signature:		**Date:**	